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ABSTRACT

A new way to view the nursing curriculum is presented based on Heideggerian phenomenology and clinical nursing knowledge research. A restructuring of the nursing curriculum based on this approach allows researchers to generate new research questions and has implications for alternative curricular and instructional practices. In addition, this reconceptualization has resulted in a new model for nursing education, the Dialogue and Meaning Model. The clinical knowledge research of Patricia Benner and the replication of her study with student nurses are briefly described. Current education research is discussed, and the implications of the research are considered, as it relates to the curricular questions of what constitutes knowledge or subject matter for the curriculum and the relationship of knowledge to experience. Also considered are: practical knowledge identified in a study of expert caring by oncology nurses, examples from critical care, examples of relational themes and nurse dialogue (i.e., the exploration of meaning among nurses), and curriculum as dialogue. It is suggested that the use of paradigm cases as a personal method for studying the development of practical knowledge in one's practice is an important strategy that could be developed in school and continued in practice. (SW)

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CLINICAL NURSING KNOWLEDGE RESEARCH:

IMPLICATIONS FOR NURSING EDUCATION

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CLINICAL NURSING KNOWLEDGE RESEARCH--
IMPLICATIONS FOR NURSING EDUCATION AND PRACTICE

This symposium is dedicated to the expert and student nurses who so graciously described for us their paradigm cases. With openness and candor, these students and nurses allowed us a privileged view into their world. To them we pay the highest accolades, for in listening to their descriptions of exquisite caring and humanity we are amazed and inspired, and have never respected them more. And to the research team of faculty colleagues and graduate students who spent the many hours needed to conduct these hermeneutical analyses of the paradigm cases, we offer our thanks. Finally, we wish to thank Patricia Benner for her consultation, her continued interest and support in every phase of this research. We consider her research to be seminal to the exploration of alternatives in nursing education.

Heideggerian phenomenology and clinical nursing knowledge research using Heideggerian hermeneutics provides a new lens with which to view the nursing curriculum. A restructuring of the components of the curriculum--a reconceptualization, if you will--is possible. Educational researchers such as Greene and Soltis have used phenomenological approaches to argue for a gestalt shift in public education away from the predominant technical model. Researchers like Apple, Katz and Feinburg have used critical social theory and more recently feminist theory to critique schooling practices and have called for the development and implementation of alternate models, particularly in higher education. Nursing education has historically committed great resources, though increasingly less, to the development of effective and efficient curricular and instructional practices. It is perhaps timely, that we take advantage of the research in education and nursing as well as some of the programmatic curricular and instructional innovations that we have developed in the past and discuss some meaningful alternatives to us as both educators and researchers.

In this symposium we will attempt to argue that a reconceptualization based on current educational research and grounded in Heideggerian phenomenology, allows researchers in nursing education to generate new question for research and has profound implications for alternative curricular and instructional practices. In addition, this reconceptualization has resulted in a new model for schooling in nursing that is a

alternative to the technical model. This model, The Dialogue and Meaning Model, is currently a theoretical model that is in its early stages of testing. A collaborative project between the University of Manitoba and St. Boniface Hospital in Winnipeg, Manitoba is using the Dialogue and Meaning Model to integrate education, research and practice through the use of this as a curricular model, as well as the use of some integrative practice models and the formation of a nursing corporation.

In this symposium, we seek to have dialogue with you about the possibilities that (1) Heideggerian phenomenology and (2) clinical nursing knowledge research, and (3) this new model offers us as nurse educators and researchers. I will begin with a brief description of the clinical knowledge research of Benner and the replication and extention of her study with student nurses. Then I will discuss the implications of this and current educational research as it relates to the curricular questions of 1) What constitutes knowledge or subject-matter for the curriculum and 2) What is the relationship of knowledge to experience. These two questions of knowledge and experience are, according to Kliebard, the essence of curricular theorizing. A part of my presentation will include a comparison of the technical and alternative models. I will argue that practical knowledge as subject matter for the nursing curriculum provides us with ways to show students the kinds of nurse-caring--that is the skilled things that nurses do as they work out their caring in practice. Following my presentation, Sharon Olsen will

describe some of the practical knowledge she identified in her study of expert caring of oncology nurses. Then Marcilee Jorgenson will provide examples from critical care. The identification of practical knowledge that can become subject matter for the curriculum is but one part of the contribution made by clinical nursing knowledge research. This research also provides a new language for the curriculum. Anne Crabtree will provide exemplars of relational themes and nurse dialogue--the exploration of meaning among nurses. I will conclude with a discussion of the curriculum as dialogue.

Background

Clinical nursing knowledge research and the exploration of alternatives in nursing education using Heideggerian phenomenology was introduced in nursing by Patricia Benner. This research was published in her book, From Novice to Expert--Excellence and Power in Clinical Nursing Practice. In this study, over 1200 nurses were interviewed for their paradigm cases. A paradigm case is, according to Benner:

> a clinical episode that alters one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current practice.

It was through a rigorous re-analysis of the clinical episodes collected from the original sample of 1200 nurses involved in the AMICAE project that Benner was able to develop a

taxonomy of nursing experience. From this data, 31 competencies or areas of skilled performance emerged. These competencies were then grouped into seven domains based on similarities of function and intent. These seven domains were derived inductively from the competencies.

Benner cautions that the 31 competencies are in no way intended as a complete or exhaustive list of nursing performance. New domains or competencies may be added or deleted at any time. In addition to providing a new kind of knowledge in nursing--practical knowledge--the knowledge borne out of experience, Benner also applied the Dreyfus Model of Skill Acquisition to the development of expertise in nursing.

According to Benner, a novice is that stage in the Dreyfus model of skill acquisition where no background understanding of the situation exists, so that context-free rules and attributes are required for safe entry and performance in the situation. Attributes of a situation are quantifiable features or properties that can be adequately explained without prior exposure to a real situation. For example, the student nurse can learn to take temperature or blood pressure readings without prior knowledge of the situations where blood pressure or temperatures are measured. Aspects of a situation cannot be described in a context-free way; and can be understood only by a person with prior experience or understanding of the situation. For example, recognizing a patient's readiness to learn requires prior experience with these concrete situations before they can be reliably recognized.

Aspects of a situation can never attain the degree of certainty that is possible with attributes or measurable properties. Thus the immediate implications of the Benner research for nursing education is the identification of the practical knowledge of nursing that can become subject matter for the nursing curriculum and an increased understanding of the role of experience in the development of nursing expertise--clinical judgment making.

Our research replicates and extends the research of Benner and uses Heideggerian hermeneutics to analyze the paradigm cases of expert nurses in specialty areas to identify the practical knowledge embedded in expert practice. We are also studying how students move from layperson to novice nurse by analyzing the paradigm cases of student nurses as they care for patients. Tomorrow the pilot data from this study will be presented by Bryne and Johnson. These studies of student nurses increase our understanding of the lived experience of students--the socialization of student nurses--as well as beginning understanding of the evolutionary process of clinical decision making of student nurses.

Students initially use the foreknowledge of previous life experienced as the background or basis on which they make clinical judgments but it is through clinical learning experiences that these are then transformed into the context of patient care situations. These studies describe the meanings of patient care experiences to student nurses as well as, contribute further to our understanding of the use of acontextual rules,

aspects and attributes by students as they enter nursing practice. Significant educational resources are committed by schools of nursing to help students safely enter nursing practice. And we should be proud of the wealth of understanding and success we have in preparing students to enter nursing practice. Alternate models of clinical instruction must build on the success we currently experience as educators while providing with new ways to view some of our current problems in clinical instruction such as declining number of hospitalized patients and the dilemma facing clinical faculty of how to both teach and maintain their clinical skills.

All of the research I have described is grounded in Heideggerian phenomenology. I would now like to briefly describe the application of this philosophy to nursing education with a description of the Dialogue and Meaning Model. The reconceptualization of the nursing curriculum as dialogue and meaning calls for a gestalt shift in our traditional assumptions about the curriculum. It is based on the educational research of Huebner, Weber and Greene. Heideggerian phenomenology provides the philosophical base by which I also draw on the work of Buber, particularly the Maurice Friedman interpretation and translation of Buber's work.

Dialogue and Meaning Model

The Dialogue and Meaning Model proposes an alternative way to describe what constitutes knowledge and a reconceptualization of the relationship between knowledge and skill acquisition in

nursing education. This restructuring has important implications for how education, knowledge, experience and expertise are defined and experienced in the nursing curriculum.

Definitions

Some terms that I feel are crucial to exploring this reconceptualization of the nursing curriculum will be defined. Knowledge in this model embraces knowledge that is instrumental, practical, and critical. Experience is defined as the turning around of preconceived notions, or the refining and elaborating of previously held beliefs, skills, and expertise. Expertise is the ability to theorize using knowledge that is instrumental, practical and critical.

Technical Model

The technical model assumes that students are given information in the classroom that they can then practicer and apply in the clinical area. Since reinforcement is important, there is an attempt to match a student who is studying diabetes with a diabetic patient or one studying problems of oxygenation with an hypoxic patient, it is nonetheless, in the technical model, desired by both students and teachers. Clinical checklists and course objectives are carefully coordinated to be sure that students have as much reinforcement of what is being learned with what is being experienced. The closer the match between theory and experience or classroom and clinical, the better and greater the learning.

Technical and Dialogue and Meaning Model--A Comparison

The assumptions of the technical model, that is the necessity for identifying essential knowledge and skills for the curriculum, and the desirability of reinforcing and matching theory with clinical experiences is restructured in the Dialogue and Meaning Model. This model describes the curriculum as having two kinds of knowledge. One kind of knowledge is instrumental and theoretical and the other kind of practical and dependent on experience. The implications of this assumption for an alternative curricular model is that knowledge can be conceptualized as "knowing that" and "knowing how." "Knowing that" knowledge is instrumental and is the knowledge of the curriculum that is taught in the classroom by teachers who are expert in theoretical knowledge. "Knowing how" is practical knowledge that is acquired through the experience of nursing. This knowledge is found in the practitioners or clinical faculty. Students begin to develop practical knowledge in their clinical experiences. Notice I did not say that this knowledge is taught by the practitioners or the clinical faculty, because clinical knowledge cannot be taught. It is personal and it can only be developed through experience. Thus expertise in nursing education is the use of "knowing that" knowledge as a part of developing the "knowing how" in the context of nursing practice. In the Dialogue and Meaning Model, the objective of clinical learning is the development of the clinical expertise of the student. This expertise is defined as the ability to make

clinical decisions that takes into account the context of the situation. This expertise involves clinical decision making but in a fundamentally different sense than typically captured by descriptions of the nursing process.

This objective of developing clinical expertise in students is not dependent on a corresponding relationship between classroom and clinical instruction. The clinical courses can be conceptualized in relation to the development of expertise, while the classroom courses can be conceptualized by the selection and sequencing of knowledge in nursing. Learning is not the transfer or application of information and, therefore, the necessity of the student to show the teacher the transfer of a skill from one setting to another or the matching of information in the classroom with phenomena in the clinical area, is not mandated. For example, this model does not require that students apply information in their care plans to show teachers that they can accurately do so. Thus the elaborate coordination of classroom and clinical teaching based on assumptions of reinforcement and a corresponding relationship between theory and practice is not necessary.

That is not to say, however, the selection and sequencing of subject matter for the curriculum does not occur, for it is important in the Dialogue and Meaning Model that faculty, practitioners and students spend time in identifying ways that the classroom content should be presented. What is desired is a wedding of the acontextual rules of the specialty areas in

concert with the emerging clinical decision making skills. The relationship between theory and practice or theoretical knowledge and practical knowledge, is transactional rather than applicational. The practice area is the place where students have dialogue with the theories they learn in the classroom. It is through practice that theories are refined, elaborated and challenged. Practice is theory generating and in this sense Heidegger's notions of practical knowledge preceding theoretical knowledge makes theoretical concerns derivative.

The intersection of classroom and clinical learning occurs at the epistomological level. Based on the research on clinical decision making (Tanner, 1983, In Press; Corcoran, 1986A & B, and Benner, 1984), student nurses use rule governed behavior to safely enter new nursing situations. The challenge for the theoretical faculty who teach in the classroom is to identify the knowledge students need to safely enter nursing situations, through the study of nursing and related fields. Currently, the rules of nursing are embedded ever more deeply in our textbooks and literature and the challenge for classroom teachers is to determine, through research and the generation of nursing knowledge, what rules and knowledge students need to safely enter practice. The challenge for clinical faculty is to develop and understand, through research, the process of how students acquire clinical decision making skills in nursing, as well as an understanding of how students use experience to learn nursing expertise.

A third kind of knowledge in the curriculum is called "critical" and it attends to making overt and conscious the issues of power and control that affect the curriculum at all levels. This knowledge seeks to provide faculty, students and clinicians with the greatest amount of freedom through dialogue identifying the issues of power and control that dominate and limit the freedom within the context of the curriculum. The issues are never limited to just the curriculum. Thus, the notion of "essential knowledge" is one around which all faculty practitioners and students have an equal interest. The Dialogue and Meaning Model seeks to lay bare the notion that there can be "consensual validation" around "essential knowledge." Research in education (Greene, 1984, and Kliebard, 1984) has indicated for a long time that faculty consensus around issues of subject matter tend to identify knowledge that is either common sense or trivial. Consider for example, who of us would argue that students in nursing do not need to know how to give an intramuscular injection safely. Consensus around this skill would be easy and almost at the common sense level. The issue for dialogue regarding essential knowledge is at another level. For example, how proficient in critical care skills should baccalaureate students be? Should they be required to develop their skills of intravenous therapy? Should mock code situations be required or optional for students? In this kind of a discussion everyone's interest is apparent. Faculty who are generating knowledge about advanced nursing practice have an

interest in students having the skills they will need to use the knowledge being generated, the practitioners desire that students have skills that they need when caring for the patients they are assigned and students want the skills they need to safety care for patients while they are in school and upon graduation. Dialogue with faculty practitioners and students around the knowledge and skills to be taught allows the identification of classroom knowledge to be more open. Similar dialogue occurs in the identification of clinical learning experiences.

Practical Knowledge--Subject Matter for the Nursing Curriculum

Using the Dialogue Meaning Model, I will now describe implications of practical knowledge of nursing. The practical knowledge of nursing has many implications for clinical instruction, but in an important way, it is central, indeed I would argue that it is foundational to the curriculum, to the classroom as well as the clinical laboratory. Practical knowledge embraces nurse-caring. Embedded within the practice of nursing is the struggle of how nurses attend to the caring of patients without distancing themselves or becoming consumed by the demands of caring. Caring then, as an ontological state, in the Dialogue Meaning Model, is foundational to the nursing curriculum.

There is a danger in treating the Benner domains of nursing practice which arose out of her analysis of paradigm cases of nurses, as taxonomies or organizers for courses or units within the nursing curriculum. To do this is to do violence to the

nature of this kind of knowledge. As educators we are familiar with organizing our courses as we do in physiology when we use, for example, body systems. Categories of information are discrete though the relationships of the categories can be very complex.

Practical knowledge in the sense that Polanyi describes it is knowledge that is derived from experience. It is characterized by perceptual grasp as in the ability to read a situation or a patient's face. Practical knowledge embraces qualitative distinctions that nurses make based on their understanding not of "knowing that," but on their practical knowledge of "knowing how." This knowledge can't be taught, but it can be shared and it is always situational specific.

Practical knowledge is tacit and exists in the finger tips of nurses. It involves guided intuition and is that knowledge borne of experience that tells a nurse something is wrong even in the face of contradictory objective data. It is reflective, complex and thoughtful. Practical knowledge is personal but not idiosyncratic. It is historical and is based on experience, but it can be shared.

According to Dunlop, paradigms and practical knowledge, do not "provide us with any universal truths about caring in general or nurse caring in particular--indeed, it does not make any such pretense. Even less does it provide us with predictability, ("knowing-that") nor does it intend to do so. What it does do is say, 'these are the sort of skilled things that nurses do, these

are the sort of ways they work out their caring in practice."

Sharon Olsen will now present some of these ways of caring--examples of practical knowledge embedded in the practice of oncology nurses. Join us now and listen to these powerful paradigm cases.

THE HELPING ROLE

I will be presenting a small sample of the data from the fifth stage of our hermeneutic analysis of 27 oncology nurse paradigms. I will address only five competencies or areas of skilled performance in this overhead of the Helping Role. And, within each competency I will provide only a single example to give you a flavor for the clinical knowledge that's embedded there. Again, the Helping Role is only one of Benner's seven domains of nursing practice. In a national survey I also conducted as a part of this study, all of Benner's Domains were represented but the Helping Role sample of over 100 oncology nursing experts as the most important domain in oncology nursing practice. Additionally, a new competency, Preservation of Diversity emerged from our data.

In the Helpers Role domain, Benner describes helping to be more than "therapeutic." It's commitment, it's empowering, and it is sharing wordless moments. Helping is contextual in that nurses provide comfort as the situation dictates, or allows. As I read through several of the excerpts from actual patient care situations this will become readily apparent to you.

Before I begin, however, I would first like to share a passage from one nurse expert that best summarizes the essence of the Helping Role.

In this exemplar, the nurse has a large background of experience, and this experience is based on a sense of connoseurship, a sense of embodied knowledge about the

population. This practical knowledge developed because of her broad and lengthy experience with nursing in general and cancer nursing in specific. You will also become aware of her sense of engagement and commitment to cancer patients, an ongoing sense of moral debate, and a commitment to flexibility. These are characteristics of expert practice and were modeled throughout the oncology nursing paradigms.

And now, in the words of this very sensitive nurse:

> Death is an upfront, scary thing, constantly with us. [I think] it's going to be very dependent on how far advanced the disease is when we find it as to where we're going to find the patient. Cancer grows very insidiously and it can be far advanced beyond our beliefs, beyond the patient's belief when they're sitting there feeling perfectly well. For some folks, we can cure them, and we do. For other people, no, we're talking months, weeks, whatever. You start giving up a lot... You start really looking at your values; looking at your own philosophy of life. You start looking at your principals--how far you can be pushed before you say that's enough. You know, I'm going to stand for this and I won't be compromised in that.

I think nursing looks at the total picture for the patient and family in relation to this illness, as well as, in relation to the wellness that they have either come from or where you want to get them back to. When you're dealing with something that is so life threatening as a disease such as this can be, you start deciding that some things just aren't worth the energy and other things are very much worth the energy. You start reassessing your priorities and organizing them.

Part of what nursing does is it helps the patient and family look at what's facing them; know what the options are; know what to expect as best as anybody can tell them so that they can make some decisions and set priorities because that's important.

I think the essence of nursing is that we do that. We don't come with a prescription that says you will do it 1, 2, 3, 4. We say, this is what's out there. We have the ability to accept people where they are. To really put that into perspective, into a framework of thought, of rights and privileges of the individual. That allows you then to say, if you decide on all this treatment I'll go with you. I personally think I would do something else, but I'll go with you because that is your decision. If you decide not to have treatment, I

> will go with you. Any complications that come up, we will take care of them, this door is open. We're here to recommend and to help. We cannot go through this for you but we can certainly try to go with you.
>
> It's hard to put the essence of nursing into a small box. I guess I have difficulty with that. That flexibility, that ability to deal with ambiguities, that tolerance of other peoples views and values, that willingness to accept people where they are... My central focus is the patient and right after that is the family and what they need and we come in the outside to help. The [family] unit are the ones that really should be controlling what we do. We give them the options, they make the decisions, we do the work. We reassess, give them more options, they make more decisions, we do the work.

In this excerpt it is obvious that expert nursing care is not power, mastery, dominance, or control. It is, however, strategies for empowering. This exemplar was an example of the practical knowledge a nurse had about the "how to" of helping cancer patients.

Turning now to the second competency.

In the following excerpt, the nurse describes a woman who is very much a "control person." It is the day after surgery and

the patient's need for control has been confounded by sleep deprivation and an earlier reaction to a pain medication. The nurse does not diminish the patient's need to control; temporarily relinquish that control. As is consistent with expert practice, this nurse was able to presence herself with the patient, to understand what control personally meant for this patient and to assist her in finding a way to temporarily relinquish that control without loss of self esteem or fear of dependency. This nurse says...

> She was crying. She was anxious... She has not had any sleep all night... [The staff nurse caring for her was very concerned saying] ... She's been very anxious. She's been keeping track of everything.
>
> The patient had a cantor tube, an NG tube, and an IV in. She had to have coughing and deep breathing and turning with inhalation therapy, people pounding on her every two hours...and then there was this whole thing with pain...and a [foley] catheter.
>
> Now this control person was trying to control all of that...and she sat right there and said to me..."and I need my medication 30 minutes before they come to do the respiratory stuff"...and I said, I'm going to give her some valium. She's so exhausted; she needs to get some sleep...[I got one IPPB treatment cancelled

> and]...then I sat down with her and said, "I know you really want to control this, can you trust me enough to let me control some of it for the day? Can you give me that piece of paper that you're keeping track of things on and let me control this so you can rest? I'll give it back to you when you've rested. I want you to get some sleep tonight, we will take care of the rest of this"... Well, they finally caught up with her, with her pain and her medication and she slept.

When providing comfort measures and preserving personhood this nurse worked very hard to facilitate independence and a sense of worth and dignity. Nurses who provide expert care know that disease, death and dying are common to the human experience but that each person's response to these is unique and complex.

We know, that frequently nurses must walk a fine line in mediating control. In this exemplar, the nurse's practical knowledge of the situation, her guided intuition, and her concern for personhood enabled her to provide responsible, moral, and ethical control.

Presencing: Being with a patient

Presencing oneself with a patient "A priori" necessitates a grasp of the patient's perspective. Those times when nurses actively engage their patients for the purpose of truly coming to understand the personal lived experience of being ill or of being a patient provide nurses with a background of experience from which they may come to view the world and help others view their

world. Such experiences become part of the personal knowledge that nurses use in complex decision making. During one interview, an oncology nurse offered the following comment concerning how a nurse comes to be comfortable with 'being with a patient.'

> I think one distinguishing characteristic sometimes of an expert practitioner is someone who can interact with people on a very equal level. Who feels confident enough in who I am and what I'm doing that I can be open enough to the experience of interacting as two human beings. Open enough to say, well I don't know about that or, that's a good question, let me find out. Not having to feel like I have to know the answers to be helpful, to be an expert.

In a different interview, this same nurse described a conversation between herself and a patient during lunch one day. The comments of the patient provided real insight into the meaning of 'presencing.' In this situation, the expert noted that "we were two people sharing a difficult experience. I had some things to give and she had somethings to give."

> In the process of this talking, she asked me a lot of questions about myself and how I lived and how I liked my life or not. We talked specifically about houses. She was obviously into interior decorating, as I am. I asked her at one point, I described these windows that I have that I don't know what to do with as far as

> curtains. I drew [the windows] for her and said, what would you do with something like this? She had a few suggestions and we talked it over.

Several weeks passed and the end of the patient's treatment came. The nurse had bought her a balloon to celebrate. The following described their conversation during their encounter in the radiotherapy department.

> So anyway, I gave her the balloon and we talked about some of her whole experience. And, that was when she talked about the dehumanizing feelings she had had. People were concerned about her skin and they were concerned about her breast. They were concerned about her axilla, but they weren't concerned about her. She said to me, the first time in this whole process that I felt like a human being was when you asked me what to do about those windows in your house. I felt like a person not a breast cancer or a radiotherapy patient and that really was nice.

Nursing has to do with being. The transaction that occurred between this patient and nurse was simple unadulterated caring based on the experts practical knowledge of how dehumanizing cancer therapy can be. This kind of nursing care is no more and no less important and therapeutic than changing a dressing or weaning a patient off a respirator.

Turning now to the fourth competency.

Maximizing the patient's participation and control in his or her own recovery

Although Benner has focused this competency on recovery--a particularly poignant example of maximizing patient control and participation was exhibited around the care of a dying patient. As is characteristic of expert practice, you will note the nurse clearly zeroed in on the relevant issue (that of living life to the fullest and being able to control ones own destiny). The nurse provided a striking example that sealed for her the importance of supporting a 70 year old woman's choice to die in her own way. Pam, the patient, coped with terminal esophageal cancer by choosing to die by "starving to death" rather than being tube fed. This nurse shared with me the following...

> [Pam] had a very clear idea about what quality of life was and to her, quality of life for one thing was eating. So, she said, I don't think I want to live if I can't talk and I can't eat. What kind of life is that?

Later in the interview...

The expert recalled a time when Pam wanted to go on a picnic andhow the staff got really involved. She said:

> The staff put in a lot of energy into helping Pam die, and Pam did too. Somebody brought in some potato salad from home and she wanted ham sandwiches. So they brought in ham sandwiches and stuff and she was going to have a picnic right here in this room. We talked

> about it [because Pam was unable to swallow] and Pam decided she was just going to chew it for the taste and spit it out, and she did. It was wonderful. She just loved that picnic and then she came in and I said, well, how did your picnic go. She said, it was wonderful, complete with ants. Somebody had drawn little ants on a piece of paper. Also, someone brought her in flowers, it was spring, flowers from their garden.

Benner has said that "In nursing we deal with reality everyday and only. All we have to work with is the person so we must come to understand him or her." This nurse and her staff sought to understand what was important to Pam and provide her, at that time, with the possibility of control in her own living and dying.

Turning to the sixth competency...

Providing comfort and communication through touch

Expert nursing care is exhibited through a sense of engagement. But, there is a particular quality to that engagement--a sense of appropriateness and rightness. By virtue of intimate exposure to a particular patient population, the expert oncology nurse comes to know that there are no words that can soothe the pain or the loss of a loved one. Often they know the only solace comes with holding and being held by another who truly understands, who was there, who also cared. The nurse in this next case combines the knowledge of "Providing comfort and

communication through touch" with that of "Presencing." The family of a dying father and a hospice nurse share final moments in this way:

> ...then I said to the three kids, you know its probably going to be real important that if you have anything to say to your dad that you say it now or if you have anything you need to do, please do it and I'll stay here in the kitchen. One by one they all went into their dad. They kissed him. They told him that they loved him. After that he died about ten minutes later.
>
> They all just kind of ambled back and walked outside and kind of got their own space. Mom and I sort of took care of what needed to be taken care of in terms of the funeral home. I went downstairs just to kind of talk with them to see how they were doing. One of the sons came up to me and said, look at the sky. In the sky there was a huge opening. The stars were just, it was just glorious. He said, I'm so glad dad died at home.
>
> We just all kind of hugged and got real supportive. There wasn't much to say. I just held them, these are two guys, 15 and 17 year old guys and we just sort of proceeded after that.

This is an example of tacit knowledge. Nurses can be taught how to be supportive during the moments of death but it is only through experience with many similar and dissimilar situations that nurses develop "know how." In this instance, it was the timing and grace with which this nurse provided support to two adolescent boys.

> [Finally, I'd like to briefly describe the new competency that evolved from the analysis of these oncology nurse paradigms...]

Preservation of Diversity:

Preservation of Diversity, was expressed in expert practice in a variety of ways. It included embracing individuality; accepting and valuing people for where they were and what their decisions were; and preserving and protecting human diversity in a system that sought to heal through domination and control.

The nurses in this study understood that humans are uniquely their own beings. That each approached life from a vantage that was rooted in a singularity of purpose, value and intent. And, that human thoughts and actions were grounded in personal experience. One expert summed up the nurse's role like this,

> So the human spirit and the strength in its ability to deal with so much, you know, I feel like saying who are we to ever think that we've got all the answers because you never know what that spirit really can do; how much resource it can come up with. Each person's spirit is different and you don't want to block them in any way. You want

to give them as much openness as there is necessary for them.

The involvement another oncology nurse had with her patient in the following exemplar displays the versatility of expert clinical practice. We clearly come to understand that life holds a very different meaning for each human being.

> [Rita had lived with her disease and multiple mutilating surgeries for eight years.] [She] came in one hot summer day and she had maggots in her, the wound that had been her vulva. I went to see Rita and she was crying. Rita said, "I keep fighting this, but that was hard to have those things on me. The nurse told me they were about as big as her little finger...I never did have a heck of a lot of good luck, here it keeps recurring, but I still want to try."

In a later scene, Rita, closer to death and this nurse (who has come to be a friend as well as a nurse) talk again:

> She looked at me and she'd just had something for pain. She was really hurting. She said you know I really think I should probably give up my life but that's the only thing I've ever had. I said, I know Rita, I know it's the only thing you've ever had and that's why you're hanging on so hard. I respect that need and I will try to do whatever I can to make it as easy as possible.

Nurse caring with this patient meant seeing the person beyond the disease and relating to them as an individual who

lived life with a worth and value that was uniquely their own. Through the eyes of the experts in this study we came to understand the individual meanings that life and death hold for many cancer patients. Oncology nurses at all times sought to insure that the individual's right to their own decision was protected and preserved. As one expert put it,

> This is how [they] perceive [their] life and you and I cannot sit here at this point in time, maybe in the future, but not today. We cannot sit here and say, you do this, you absolutely get better. It's all going to be okay. There's no way we can say that. We can only tell them what is there, what we know and then it's their choice. My bottom line has always been, we go with them. They can always change their mind.

In conclusion...

I am proud to count myself as an oncology nurse and at the same time humbled and awed by the scope and breadth of the clinical knowledge embedded in our practice. Prior to conducting this research, practical knowledge was taken for granted, as just something you learned from experience. I now understand and value this knowledge and invite you to hear a small part of the clinical knowledge embedded in the expert Critical Care Nursing paradigms that will be presented by my colleague Marcilee Jorgensen...

Thank you.

The skilled-caring displayed in the every-day acts of expert nurses was expressed throughout the critical care nursing paradigms. Helping, as an expression of nurse caring assumed great importance. Through critical care paradigm cases we see helping as it occurs within the context of critical care nursing and the meaning ascribed to this domain by these experts. I will first provide an overview of the domain and then exemplars for some of the competencies.

Berger and Luckman have written, "Put simply, through language an entire world can be actualized at any moment, language 'makes perfect' for me not only fellowmen who are physically absent at the moment, but fellowmen in the remembered or reconstructed past."

Through the language of critical care nurses we envision the world of critical care nursing and the meanings that lie therein.

Helping in the ICU means learning to cope with high stress levels. Nursing is a transactual event; therefore, nurse-patient relationships in the ICU occur at different levels when patients' abilities to interact and respond are compromised by illness, injury, or treatment. One nurse interviewed had made critical care nursing a life career. This nurse expressed how she came to learn how to both continue to help critically ill patients and to survive this toxic environment. She says,

Exemplar: The patient's there on a respirator and I'm assessing that patient...there's numbers, the goal is to detect and get the patient well. I'm not having the same communication and interaction with the patient as

> I am with the family. And, I don't want the tape recorder to view me as not talking and touching the patient. I am, but not on the same level. I always remind myself that there's going to be another patient, and if I give a hundred percent or 150%, there'll be nothing left over of me to give. And, I want to stay in nursing bad enough that I don't give 100%. I also have "head" times; I sit back and evaluate my priorities, and I know I'm a wife and mom first. And, there were times where I was so tired and exhausted that I had nothing left for my family. There was a point that I could be throwing up and I'd have gone to work. Now, if I need a mental health day, I call with no guilt and say, Hi, I'm not coming in today. And, I think I've really come a long way and I'm a better person for it. Person and then nurse... Because I think that's what you bring to nursing, the person you are.

The nurses in these paradigms struggle with how to attend to the caring of patients without distancing themselves or becoming consumed by the demands of caring. There are patients with whom ICU nurses do become deeply involved. The intensive care unit is recognized for its technical accomplishments in saving lives; this may foreshadow the intensive caring that expert critical care nurses do for people there. Dr. Patricia Benner speaks of helping as sometimes having the courage to be with patients,

offering whatever comfort the situation allows. It is the expert nurses who come to rejoice in and value personhood in an ecology where technical expertise is highly prized. One expert stated,

> Exemplar: You know, I know how to figure out the cardiac output and how to titrate dopamine, and I know all these little numbers, and I think that's important, not that you have to know it off the top of your head, but it's important that you are able to know where to find the information you need and keep up on things. But, I think you need to be able to touch people, too. Because, if you don't, I don't think the next guy's going to either. And, sometimes I think that's the most important thing we do in nursing. You know, by touching that person, you're going to be able to help them. You're going to be able to still do the rest of the things, and they may be more important at times. People have told me that I get a little too involved...and I probably do...but it sure feels good to cry sometimes.

There is always an emotional risk in becoming involved with patients who may not survive. One expert discussed this in her reflections about her care of a critically ill patient who dies. Her ability to grow and her transformation following the experience was reflected in her remarks.

> Exemplar: Well, this was probably the first patient that I really had gotten involved with up to my ears. You know that I was physically, emotionally, and

> spiritually involved with. And, I had my hopes and his hopes, and I spent many, many shifts working with this man. And, I knew his family real well, and I think it really pointed out to me my vulnerabilities, you know. I guess I didn't really change how I get involved with patients, but it has really opened my eyes to who I am, and how I feel. I really had never lost anybody I was close to like that before.

Nursing care as helping is transcendent of the more narrowly defined therapeutic role traditionally ascribed to nurses. Dr. Benner describes helping as encompassing transformative changes in meanings. In the ICU, to continue to help in the most extreme situations, requires an understanding of one's own personhood. Nurses in the helping role are responsive to a patient's sense of being-in-the-world; in this process they become aware of their own structuring of the world. It is through this perspective that nurses offer help.

I would like to continue by describing the transformative changes of the "knowing that" of helping to the "knowing how" or practical knowledge of helping in the ICU--the knowledge of helping as it is embedded in the paradigm cases of nurse experts.

The Healing Relationship: Creating a Climate for and Establishing a Commitment to Healing

ICU nurses work with patients whose lifestyles have been drastically changed because of their illnesses. Embracing the possibilities and maintaining hope in the face of desperate and life-threatening situations are hallmarks of expert critical care nursing. In the following exemplar, Jean, the nurse, described caring for a middle-aged man with severe cardiac disease who awaits a heart transplant. Jean related,

Exemplar: One of the things that I used to enjoy was to go in and sit with him, and he'd like to lie in bed, and we'd shave him because he didn't have the energy to shave himself. And, we'd sit and talk about the things that he wanted to do after he had the transplant and, oh, just talk about what having all the new energy would mean to him. He'd had bypasses in the past, but now he had an ejection fraction of about 20%. Simply getting up and getting out of bed was a very fatiguing process for him. And, we'd sit in there and talk about what they were going to do to him, and how he was looking forward to being able to go out and walk in the fields; just things that he hadn't been able to do for a long time.

After the procedure, Jean again displayed a commitment to handling and an emphasis on optimism: Quote--

...and one of the first things I did was to go into the room to shave him, and he looked at me and smiled, and

> he said, you don't have to do that any more because I can do that now. And, so I just sat around and teased him while he was shaving--told him you've just been lazy before and you could have done that; it was just because you were trying to see if we'd do it for you, and he laughed. It turned out that--I didn't know this before--but when my birthday came around, it turned out to be his birthday. So, we set up a system that he was going to have two birthdays--the birthday that marked the anniversary of his birth and the birthday that marked the anniversary of his new heart.

The practical knowledge which accrues with time and experience allows this expert nurse to realize the possibilities, to offer hope for the future.

Providing Comfort Measures and Preserving Personhood in the Face of Pain and Extreme Breakdown

The intensive care unit can be treacherous territory for both patient and family. In this world, life and death hover in tenuous balance.

The ICU is a world of objectivity, of external realities. It is hard-core, state-of-the-art medical technology and at times assumes a sterile and coldly impersonal stance. Continually confronted with crisis situations, and encountering tragedy upon tragedy, it may become a manner of coping for nurses to secrete away those emotions and blunt those responses that attend to the human element. It is the expert ICU nurses that enable humanity in this world through their acts of caring and personal kindness.

The primacy of caring is explicit in one nurse's struggle to preserve personhood by allowing the completion of a lifecycle, in permitting death to occur as an intrinsically human event. The patient, Susan, is a young wife and mother and is diagnosed with aplastic anemia. Susan is described as a "fighter," struggling to defeat this disease that threatens to take her life prematurely. Each successive medical treatment fails, and there is increasing desperation on the part of the medical staff. A final futile attempt is made at a mismatched bone marrow transplant; Susan goes into graft-versus-host rejection, and ultimately arrests. The expert related the following events,

Exemplar II: I just yelled for help, but, of course everybody else was busy, and finally someone from the floor heard me yelling, and a blue-cart was called, and her husband was down there in two seconds, and it was the type of thing where you don't usually let family in for a blue-cart...and I said, he has every right to be here. He's been through every part of her treatment...and, in fact, they had just taken bone marrow from him the day before. At first the doctors didn't want him in the room, but I said, no, he can be here. People tried getting him out, and I said, no, let him stay. He looked at me and shook his head and said, please don't prolong this any...and I'm doing chest compressions and crying, you know, like you guys, you can't do this, make it short. She didn't want anything more done, and he didn't want anything more

> done, and they knew it was the ultimate. So we ended up coding her for about half an hour, but we knew it was over.

The medical team that responded to the code did not know this patient and her family; they were reacting to a symptom, a heart that had stopped. The nurse knows technically she must go through the motions since Susan was still a full code; however, she knows that this is not what Susan or her husband wanted. She struggles to spare them both a prolonged and brutal death.

Quote--

> They were the ones (referring to the code blue team) who wanted to keep going, and that's when I said, no, she didn't want any more, and make this as short as possible. And, as I was doing chest compressions, I had to more or less just relay history to them...just a quick synopsis of what had been going on and where she was, and I think, after that sunk in, plus the fact that we couldn't maintain her pressure,...they said, well, I have to do what I have to do; this is my job, and since she was a full blue cart, I just made it very clear to them to do just the bare minimum that you have to do; don't prolong this.

On reflection, the nurse continues,

> ...Ah, Susan that day; Susan was not alert or anything. She was pretty much comatose at the time, so I don't know if she knew that I was there or not; you know, who knows? But, to me, I feel that I needed that, too...I

had to see it to the end, and I'm glad I was the one that was there.

After the code is over, the husband thanks the nurse and says, "I'm glad she died with you."

Nursing in the ICU required nurses in these paradigms to carefully differentiate between prolonged death and prolonged life. The ICU, as a symbol, represents humankind's attempt tc triumph over death. It is in the ICU, perhaps more than any other place, that we see this intense struggle to preserve existence despite the odds and in spite of the consequences. Nursing, as an act of humane caring and helping, must look beyond the defining of life in physiologic parameters.

Providing Comfort and Communication Through Touch

The ICU is often a world of medical surrealism to patients and their families; there is the flashing digital displays of monitors, the clicks and bellowings of artificial respirators, and caretakers who are often indistinguishable from one another when clothed in surgical garb. In this technologically governed world, the simple acts of human-to-human contact become rare gifts. It is the expert who enables comfort and communication through touch in the ICU. One nurse was able to help a young couple through the devastation of illness by encouraging the wife's participation in care. She told,

Exemplar: And, I just started letting her do things as far as mouth care or helping when we turned him and let her rub his back, and, you know, just little physical-type cares, and she, even when he had to be suctioned,

sometimes she would leave the room; sometimes she would stay just to hold his hand because he wanted her there.

The patient in this paradigm is terminally ill. Shortly before he dies, the wife asks the nurse about bringing their one year old child in to see his father. The nurse responded,

Exemplar II: And, it was probably three or four days before he died that she questioned whether she should let the baby come down, because her parents were coming up with the child, and I said, I think Pat needs to see him one more time, and he was still alert enough that he knew the baby was there. I said, I don't think it's something that the child will remember, and I'm sure he'll forget about it, but I think it's important that they see each other, and so they did let the baby come in, and, you know, like he hugged him and sat on his bed and stuff, and it was, it was kind of, it was real gratifying in a way....

So, silhouetted against this medically surreal world, there is an act of humanity, of love, and of normalcy when this father was able to hold his child one last time.

So we come to know, through the paradigm cases of nurse experts the practical knowledge of helping--the difference between "knowing that" any further medical treatments would be futile and "knowing how," in the face of such a realization, to provide a humane completion of a life cycle.

Next Anne Crabtree will address a relational theme, death and dying, which emerged from expert critical care paradigm cases.

Death and Dying--A Relational Theme

To understand the complexities of a particular sphere of nursing practice, it must be viewed from the cultural context in which it resides...So that nursing practice in the ICU, like oncology, or obstetrics or community health nursing is framed within a specific ecology.

Embodied within these paradigms are displays of nurse-caring which explicitly demonstrate the relationships and issues that are significant to and uniquely owned by nurses.

Death and dying as a common human experience has been translated into unique themes within the various specialty areas of nursing practice. The human concerns and needs associated with a death experience are essentially unvaried,...that is, we may assure ourselves that people desire and will continue to desire a death which is swift and painless, compassionate and merciful.

The most difficult aspect of this research process is the discovery and development of the relational patterns or themes embedded within these paradigm cases. The goal is to articulate the themes without sentimentalizing or oversimplifying them. To remain true is the challenge.

The theme we are about to explore is a view into the experiences that expert critical care nurses have with death and dying. These themes compose the intricate tapestry against which the activities of these experts are portrayed. Their commitment to caring and dedication to the preservation of personhood is equally intense in all specialties, as these are the hallmarks of

expertise and excellence in practice. However, the manner in which each is played out, and the price that is paid by these individuals is uniquely reflective of the arenas in which they work.

The themes are the essence of practical nursing knowledge, and it is through them that we may begin to dialogue with novices in a way that reconstructs the experiences of nurses.

These themes can become the "knowing that" of skilled nursing practice. The importance of capturing them is founded on the idea that they may be the truest and most valid form of theory, theory which is abstracted from the everyday activities of nurses.

So now I invite you to listen and take stock of,...to reflect and to reference,...and above all to hear of the common but not insignificant experiences of the nurses in these paradigms.

Time has many faces in the ICU; it can be an endless waiting, biding and vigilantic; for once treatment is initiated, there may be no other alternative except to allow time for healing. It can also assume a moment-to-moment staccato-like quality, where each minute is determined by a presenting symptom and a corresponding response from protocol. It is this continuum that lends a unique quality to intensive care nursing. Life and death have never been closer to each other than in the ICU, and all the drama of these events is contrapuntally played out against the passage of time. One expert nurse reflected upon this:

> I think there's definitely a difference between critical care and other kinds of care. I think the needs--physical and emotional--of the patient and family are amplified in critical care; the nature and intensity of the work is different. It's all more immediate.

Significant to this aspect of ICU nursing is this expert's story of a young patient, who, previously healthy, is admitted to the ICU with an acute viral cardiomyopathy. A rapid and fulminant disease progression takes this patient's life three days later. In this period of time the family experiences the loss of a once relatively healthy son. This nurse noted,

> All of that experience, all of the significance of that event, in that patient's life was crammed into three days--all of that physical and emotional challenge was packed into that short period of time ...Sometimes a lifetime is that day.

The implications of this observation are enormous for the critical care nurse who cares for the dying patient and his or her family. According to a phenomenological study of expert oncology nurses done by Olsen (1985), for the cancer patient and his/her family life is referenced by death. Death in oncology nursing is treated as a life event, and the role assumed by these nurses is one of making this experience as "good" as possible. This often entails a lengthy and deep involvement with such patients and families in order to learn their interpretations, values, and needs. The luxury of time is not always available to

ICU nurses. Additionally, the patients themselves present at varying levels of consciousness. Lastly, nurses in these paradigms seem to have a different philosophy and stance toward death. An expert nurse, whose paradigms revolved around helping families make difficult decisions regarding prolonging life support measures had this to say about this aspect of intensive care.

> I'll tell you one of the dangers or hazards of involving yourself with meeting the needs of dying patients, or associating with dying patients, is that people start labeling you that way. You know, the physician will say, Wouldn't you like to see this person live? And some of the nurses have called me "the angel of death," things like that. So, it's kind of striking a taboo in medicine to recognize that people are dying. Especially in high-tech, high-activity areas. You know, we have more patients die because of the high acuity, but there's a stronger tendency to avoid that whole issue, because your orientation is so strongly toward research and trying new things.

Death in the ICU for another expert was coined "an unusual event." This remarkable choice of words strongly suggests an attitude which has created great controversy in the ICU. Death is most certainly a usual event, as every person is sure to experience it. However, when asked what their number one

priority was in caring for the critically ill, ICU nurses unfailingly responded, "Seeing that they don't die."

It is in this world where we see nurses and doctors struggle to maintain the competency of failing organ systems. Death, once denoted by the cessation of the heartbeat and respirations, has been transformed in the ICU; it has become a symptom, a sign of danger that demands immediate response and treatment. But patients do die in this world where death is unacceptable. For example, the patient who dies of a widespread cancer, cancer that was "eroding his whole body." In response to a medical student's comments about this patient--"He was so nice; it's too bad he died"--this ICU nurse says, "Sometimes death is not so bad." The interpretation of death as being good or bad has created a conflict and ambiguity that ICU nurses live with on a daily basis. There is a tendency to look for causal factors; whether medical mismanagement or limitations of current technology, there is always a reason for defeat. Assuming the responsibility for life and death has created a moral and ethical quagmire for ICU attendants. Armed with an arsenal of sophisticated technologies, we now alter what was once destiny. The questions we now ask are, how much further can we proceed? How much longer will this continue? We are troubled and disturbed in the ICU; in this societal microcosm we see both the empowerment and imprisonment of our technology. Death is defeat and yet it is inevitable. This expert ICU nurse speaks of how she has come in terms with this.

I guess you have to sit back, and one thing you have to

> try to avoid is finding fault--whether or not there is fault. Yes, sometimes you could have changed this or that, but I think, basically, their time is up.

The consequences of defying death have also become apparent to ICU nurses. We are easily guiled into believing we have done good in saving lives. We see, however, that life and death are not easily amenable to the "either-or's" of good and bad.

This expert responds to this question.

> I think I'm much more realistic as far as what to expect. And I've also found I used to feel good if you'd see somebody through a massive infarct and they didn't die. But the quality of life in some people, if they survive--I question this; what are we doing here?--because they've lived.

Defining life by physiologic parameters may pose a dilemma our entire society may soon face. In the meantime, it is occurring every day in the ICU, and it is the expert ICU nurse who struggles and dialogues in not only asking the questions but in seeking the answers.

Now Nancy Diekelmann will summarize with an explication of the curriculum as dialogue.

Dialogue

In D & M model, the curriculum exists as dialogue among teachers, practitioners, and students of what will constitute the knowledge of the nursing curriculum and the role that experience will play in the curriculum. The curriculum is what it means to be a faculty-teacher- researcher, a practitioner-teacher, and a student nurse. The curriculum is both constituted and constituted by these people.

In the Dialogue and Meaning Model there is no higher court for discussions than occur among the faculty, practitioners, and students involved. Dialogue is more than conversation for it is being-in-the-world with each other through language and experience. In dialogue, the assumption is made that decisions are only meaningful in the context in which faculty, students, and practitioners experience them. Enlightened debate then, in which the issues and all the complexities involved included those of power and control are fully discussed, does not necessitate a vote or consensus to become operational. To understand a "problem" from a new perspective, to be-in-the-world through a new lens, is to understand what the "problem" means. The "solution" then is achieved contextually, since everyone, teachers, practitioners, and students, will in their own way attend to the new meanings they have experienced.

Dialogue is a joint reflection on a phenomenon: it is a deepening of experience for participants. It is talking, generating questions, and possible interpretation. Dialogue involves the lived experienced of everyone and seeks shared

understanding. Buber and Friedman describe the "between," that is the "seeing between" (entre vous), or meeting to share a viewpoint and revealing and permitting understanding. According to Weber, "It is the seeing of that which is neither only you nor only I, but is rather our between that we learn about each other.

The curriculum as Dialogue and Meaning is a community of scholars, researchers, teachers, practitioners, and students who together think things through, glancing at the mirrors others hold up for us, discovering not only the other, but ourselves. Dialogue is thus both private and confidential, as well as social and public. It is oral discourse. The curriculum previously defined as a set of beliefs that provide a framework that guides selecting and sequencing of courses in a school is replaced by a process--dialogue--that acknowledge all as participants in the curriculum and as human beings of importance. It involves people who understand education, research and nursing. Dialogue is respectful, open, responsible, and implies a willingness to learn.

The "problems" of the curriculum are "solved" through dialogue in which there is an openness of questioning. Heidegger describes dialogue as, "...the very act of posing a question is disclosure, for to question is to sketch in advance the context of meaning in which a particular inquiry will move." The answering in turn invites more questioning, also guiding the dialogue. The dialogue is thus shaped by all, becoming, for the moment, "their shared abode" (Weber, p. 69).

Dialogue as Praxis

Faculty meetings and committee work are common activities in the technical model. The Dialogue and Meaning model replaced all these various committees with a regular meeting of the community composed of all the faculty, practitioners, and students--all with equal membership. Concerns affecting the school are discussed. The curriculum is a negotiated curriculum. Certainly there are limits to this model, such as university requirements that only tenured faculty make personnel or budget decisions or university-wide mandated committees. But to the extent possible, all problems, issues, and concerns are brought to the community for dialogue. If it is the decision of the community that a committee should be formed to investigate an issue, then one is formed. However, when the committee has done its work, it is dissolved. As much as possible, all members of the school are equally informed through participation in dialogue.

An example of this kind of dialogue would be dialogue in which clinical faculty feel they are not being included in classroom instruction. Dialogue among teachers, clinicians or clinical faculty, and students would not just seek to make visible specific instances of grievances and possible solutions to decrease the conflict of both classroom and clinical faculty. Rather, through dialogue, members would seek to understand the lived experiences of the other. What does it mean to be a classroom instructor, a part of which is relating to clinical faculty in many agencies? How do I as a classroom teacher experience the need to provide for clinical learning experiences

within the context of my course? What do clinical learning experiences in my course mean to students? And, as a clinical instructor, what conflicts occur as I try to plan a meaningful clinical learning experience for my students in the context of my clinical unit? How do students experience the relationships between classroom learning and clinical learning and between classroom faculty and clinical faculty? And what does it mean to them to be told one thing by a classroom teacher and another by a clinical instructor? Another level of dialogue could involve debate on the relation of classroom to clinical teaching and some possible alternatives. What function is served by having faculty in adversatial positions regarding questions of course planning? How are the issues of power and control experienced by both classroom and clinical faculty as they plan and coordinate their activities?

Dialogue does not rush into "finding a solution," it seeks rather an enlightened understanding. Solutions that are acontextual are rarely effective or needed in school of nursing. The dilemmas we experience in schooling and practice are too complex to lend themselves to easy solutions. But through dialogue, needed choices both at the curricular and instructional level, are best made from a position of heightened awareness and understanding. Then each teacher, student, and practitioner, individually and collectively, will make the choices that seem most meaningful to them in the context of specific situations. This is not to say that group solutions to curricular problems do not need to be made at times. Rather, it suggests that most

solutions are so contextual that rules as solutions are not possible or productive. To be effective, group solutions, policies, and rules must always be carried out contextually in a meaningful way in the day-to-day lived experiences of teachers, nurses, and students.

Sometimes through dialogue, faculty, practitioners, and students experience the "meaningful silence" of listening and thinking, participating at times more through gestures than through speech. Dialogue is experiencing moments of judgment and emotional reactions. Sometimes it is the silent reaction of "how interesting" or "I know how she feels: that happening to me too" or perhaps "How different from my own experience this is." But dialogue always affects everyone involved, or it is not dialogue. It continues long after the participants have departed. This is often experienced as recall or reflecting; for example, "I wish I had asked or I'd like to know..." According to Weber, "One dialogue echoes thoughts of another and through persons, ideas are changed, challenged and tested."

In the Heideggerian sense, it is the experiencing of a common culture and language that we share as nurses. It is only through language than that we experience the nursing curriculum as dialogue and meaning. In recent years curricular studies have focused on the language of the curriculum. But before I leave my description of dialogue, I would like to present some dangers of dialogue.

Dangers of Dialogue

The nature of the community of teachers, practitioners, and students is based on "I-Thou relationships" (Buber). Through dialogue and "I-Thou relationships," there is the potential to develop trust, commitment, and growth of new human relationships and deepened understanding. The danger is that "I-It relationships" can occur that undermine trust and growth. For example, a member who communicates, "I want to know you-as-you as long as I find out about it or whatever my particular need or concern at the time is," or "I won't open up myself to you and I don't really care to know you, but I will go along with this in appearances only, because for some reason, it is to my advantage." This kind of relating betrays dialogue. Dialogue is authentic; it is a willingness and trusting to learn as much about each other as we learn about whatever the topic of discussion is. It is experienced as a power of encounter.

Dialogue is a new way of "Being-in-the-world" for many and thus can be threatening. A danger is that participants will stop listening, presencing themselves, or even denying the possibilities that evolve through dialogue. It must be clear to the community that having thoughts or feelings (particularly negative one) about a person is not a betrayal of what it means to be a participant in dialogue. On the contrary, it is only in relating to the other as one human being to another that these feelings are transformed into new possibilities.

Summary

The implications of clinical knowledge research for nursing practice include making visible the excellence in practice and documentation of the practical knowledge in nursing so nurses can take and receive credit for this important part of practice. The use of paradigm cases as a personal method for studying the development of practical knowledge in one's practice is an important strategy that could be developed in school, but continued into practice. Wouldn't it be exciting to have students enter graduate study with a portfolio of his own paradigm cases which could be the basis of their masters study?

But the implications of clinical knowledge research are also great for nursing education. Combined with the plethora of creative and innovative clinical and classroom strategies and encompassing recent trends in research in education, particularly higher education, Heideggerian phenomenology provides a new lens for viewing the nursing curriculum. By rethinking the relationship between classroom and clinical learning, new programmatic possibilities arise. The possibility of replacing the curriculum as a road map or list of courses some prescribed and others optional, with a view of the curriculum as dialogue allows us the opportunity to develop curricula in which the faculty's interests and expertise drive the curriculum rather than vice versa. At a time when the mandated entry into practice is necessitating a rethinking of the differences between Associate degree and professional nursing education, the consideration of alternate curricular models than can replace the

technical models currently used is many AD and Baccalaureate schools is timely. The Dialogue and Meaning model based on Heideggerian phenomenology is one such alternative. The inclusion of practical knowledge—paradigm cases of expert nurses is another alternative. All of these approaches and models need to be carefully studied and evaluated.

I would like to conclude with an excerpt from one of our paradigms because this expert nurse so ably describes the process with which we as educator struggle as we seek to better understand our schooling of nursing students and try to embrace new ways, new alternatives.

"We dialogue. We tell our stories to each other because those are the times that you grew. They had importance for you somewhere, someway, or you wouldn't even remember them. They either confirmed something; they changed your attitude about something; they added a piece to what you already had; maybe they took it away if it was too painful. But we all have them and we need to learn by them. And that's the only way we can advance or expand--is to be exposed and then do something about that exposure, in some way."

Thank you.

Appendix A

A third assumption of the technical model is that all students ought to experience every specialty area of nursing or as many as possible. This assumption may be operationalized as a required community experience or operating room experience or a required experience in pediatrics. Faculty, practitioners and students alike embrace the notion that an exposure to all of the specialty areas is essential if the student is to make the appropriate job related and career choices following graduation.

The third assumption of requiring that students have at least one experience in each specialty area or that some specialty areas or experiences are mandated, is not necessary in the Dialogue and Meaning Model. It may be that a particular school through dialogue with faculty, practitioners, and students decide to require some, but the rationale would not be so that students would be better prepared to select the area they are most skilled in and enjoy to practice after graduation. These choices are best left to the student's discretion.

The rationale for specifying clinical experience should not be related to the job needs of the specialty but rather to the needs of the patient populations being served. Thus, it is possible to learn about caring for the chronically ill by caring for either children or adults. That is not to imply that there are very different needs related to each of these groups. If, however, the objective of clinical instruction is to help students learn the rule-governing behavior, as a part of developing nursing expertise that is necessary to safety care for someone with a chronic illness, the patient population is but one variable. The provision of experiences for novice nurses that leads them from rule-governed behavior to the development of a sense to attributes and aspects that is generalizable, is possible in any nursing specialty.

Providing students with the opportunity to control the rate at which they change nursing specialty areas, as well as nursing units, supports the research of paradigm cases of student nurses in which they reported that constantly learning new units and nursing specialties interfered with their ability to enter and experience the nursing culture (Bryne, 1986). Students described understanding and in some instances accepting the "cold reception" they received as being legitimate, since they reported that often they did not know what they were doing and had many questions that staff had to answer.

In the Dialogue and Meaning Model attention is paid to both the issues of socialization, as well as learning of the necessary clinical judgment skills. This model is based on the development

of new collaborative relationships between teachers and practitioners that would allow all hospitals to be the laboratories for students learning nursing, and that nurses would be experiencing as a part of schooling a caring environment in which they are valued by all nurses as a rich resource for the profession. New titles and creative use of hospital and teaching positions can make possible new levels of collaboration. For example, Professor-Clinicians who are doctorally prepared but who are hospital-based could as a part of their clinical assignment facilitate the learning of clinical students at all levels. Allowing masters students, two senior students, two junior students and four sophomore students on a unit, all with different objectives, could provide an opportunity to students to experience the nursing culture ion new ways as they develop their skills and expertise in nursing. Staff nurses could be involved in clinical instruction in ways that are not dependent on classroom activities. Students could choose to stay on a unit or in an agency for more than one semester or could choose to specialize. Allowing them an opportunity to experience the nursing culture over time.

Allowing students the option of specializing at the baccalaureate level is also congruent with the research on clinical decision making. Benner (1984) has documented that it is through developing a sense of attributes and aspects that expertise is developed in novices. In order for aspects and attributes in a more generalized sense to occur, the students must have sufficient enough similar experiences to make this kind

of judgment. For example, to learn when to make the clinical judgment of whether a particular blood pressure is meaningfully low or when a patient is cyanotic, the student must have sufficient enough experiences in which the opportunity to make these qualitatively graded decisions are possible. One way to maximize this kind of decision making experience is to provide students with the opportunity to control patient populations.

The Dialogue and Meaning Model reconceptualizes the curriculum and assumptions of knowledge, experience and expertise. There are other important assumptions regarding temporality, Being, and language that have not been explicated but that also underlie the model. The meaning of these possibilities will be experienced as true alternatives to professional nursing education are explored.